Direct Line Consultancy Services Limited

DLCS Wickford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection, which was announced, took place on 28 December 2017 with follow up visits and phone calls on 29 December 2017 and 2 January 2018. This was the first inspection of the service, which is a domiciliary care agency providing personal care and support to people in their own homes. At the time of inspection, 29 people were using the service.

There was a registered manager in post who was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider also managed another service, which had recently been inspected and rated as 'inadequate'. Many of the issues found at the other service had been highlighted as a cause for concern at this service. However, these concerns had been partially mitigated due to the employment of a new management team who were responsible for the day to day running of the service. This factor together with input from the local authority had resulted in improved systems and processes. Consequently, many improvements had already been made and others were planned.

People, staff and relatives were positive about the new management structure and reported progression in the quality and effectiveness of the service. Staff morale had improved and there was a sense of teamwork and a commitment to providing a good service. People's feedback regarding the quality of the service was actively sought and was used constructively to make improvements.

There were sufficient staff employed to meet people's needs. Care staff were not rushed and had time to spend with people. Staff were usually on time for calls and there were no reports of missed visits. However, recruitment processes for care staff required strengthening to ensure staff were recruited safely.

Staff had received training to support people to take their medicines. Improvements were required to ensure more robust assessment and monitoring of staff competence to ensure staff had the skills and knowledge to safely manage people's medicines.

People and their relatives said they felt safe using the service. All staff had completed safeguarding training and there were systems and processes in place to respond to incidents or allegations of abuse.

People had risk assessments in place, which provided detailed guidance to staff on how to minimise risk. Accidents and incidents were recorded by staff and shared with the management team who took the appropriate action to minimise the risks of reoccurrence.

The service provided staff with an induction and training, and supported staff through observations and supervision of their practice to support staff with their learning and development. At the time of inspection staff had yet to receive annual appraisals of their performance however, these had been scheduled for 2018.

People's consent was sought before care and support was provided. Staff and the management team were aware of the requirements of the Mental Capacity Act 2005 (MCA). Assessments of people's capacity and best interest decisions were made appropriately, in consultation with relevant parties.

The service supported people to have enough to eat and drink and helped people to access healthcare services if needed.

Staff were caring, courteous and respectful of people's privacy and dignity. People were listened to and included in decisions about how they would like their care and support delivered. Independence was supported and encouraged.

Improvements had been made to the quality of information held in people's care records. This meant that staff had access to more detailed guidance to enable them to provide care and support that was tailored to each individual and met their needs and preferences.

There were policies and procedures in place for managing complaints. People knew how to complain though lacked awareness about who the registered manager was. People were familiar with the care manager and care supervisor and knew how to contact them to raise any concerns. Records showed that complaints were dealt with appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Recruitment processes were not always robust.

Improvements were required in monitoring staff performance to ensure the safe management of medicines.

Staff were aware of their safeguarding responsibilities and knew how to protect people from the risk of abuse.

Risks to people were identified and managed safely in a way that protected people's rights and freedom.

Is the service effective?

Good

The service was effective.

Staff received training, supervision and support with professional development to be competent in their role.

Consent was gained from people and staff knew how to support people with decision-making.

People were supported to have enough to eat and drink and access healthcare services to help them maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and listened to people.

Independence was supported and encouraged.

People's privacy and dignity was respected and upheld.

Is the service responsive?

Good

The service was responsive.

Care and support was tailored to each individual.

Staff knew people well and met their needs and preferences.

People knew how to make a complaint and complaints were dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not always independently identified areas requiring improvement.

The new management team were well thought of by people, relatives and staff.

There was a strong sense of teamwork and staff enjoyed working at the service.

Feedback from people was actively sought and used to drive improvements.

DLCS Wickford

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days, was completed by two inspectors and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service so we needed to be sure that someone would be in. We visited the provider's office on 28 December 2017 and on 29 December2017, we completed two home visits to observe staff providing care and support to people in their own homes. On 2 January 2018, we carried out telephone interviews with people who used the service, their relatives and staff.

Prior to the inspection we reviewed information we held about the service. This included a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at questionnaires, which had been completed by people who used the service and also looked at statutory notifications that the provider had submitted. Statutory notifications contain information about important events that happen at the service, which the provider is required to send to us by law.

During the inspection we spoke with five people who used the service and two relatives. We spoke with the registered manager, the care manager, the supervisor and five care staff. We also obtained feedback from the quality improvement team of the local authority where the location in based. We reviewed five staff files relating to recruitment and supervision, medication records, staff rotas, policies and procedures. We also looked at compliments and complaints, incident and accident monitoring systems, meeting minutes, training records and surveys undertaken by the service. We looked at six people's care records, which included care plans, risk assessments and daily notes.

Requires Improvement

Our findings

Prior to our inspection concerning information had been shared with us regarding how the service managed risk to people's safety. However, during our inspection we found the provider had addressed their failings in this area and we found that people had individual risk assessments in place that were completed in line with people's identified needs. There was clear guidance in place for staff to mitigate risks that were organised and easy to follow to keep people safe. For example, where a person had been identified at risk of choking, they had a risk assessment and management plan in place, which clearly stated that the person required a thickening agent, with instructions for staff on how many scoops to add to liquid to enable safe swallowing.

Risks relating to people's mobility needs had been identified and people were supported to move around their homes safely. We saw guidance in one person's care plan, which stated; "Encourage [named person] to use their walking frame when mobilising around the house. However, [Named person] will sometimes use their walking stick instead. [Named person] is aware of risks but has full capacity to make their own decisions." This demonstrated that risk was managed positively to ensure that people's rights and freedom was protected. Staff were able to explain how they would keep people safe. One staff member told us,"[Named person] can't stand well so we always make sure they have their frame." And, "[Named person] can get sore skin so we need to make sure we keep them clean and apply cream."

We had received information of concern that the provider's recruitment process was not robust to ensure staff were recruited safely. Concerns had been raised regarding a lack of Disclosure and Barring (DBS) checks on staff. The DBS carry out a criminal record and barring check on people who have made an application to work with children and vulnerable adults. This is required by law to prevent unsuitable people from being employed. During our inspection we found the registered manager had addressed this issue as they had paid for all staff to have a new DBS check and annual subscription with the update service. This meant the provider had access to the most up to date information about staff.

References had been obtained prior to new staff starting work. However, these references were not always robust as some had been provided from personal email addresses and had not been verified to check their validity. In one instance, the references obtained for a person were not from their most recent employer in the care sector. Providers are required under the Health and Social Care Act to obtain satisfactory evidence of potential employees conduct in previous employment in health and social care services and the reason why their employment ended. We discussed our concerns with the registered manager who was aware that improvements were required to ensure a more robust recruitment process. They told us that a new

recruitment process had been designed but it was not possible for us to assess this as no new staff had yet been recruited.

We asked people and their relatives if they had any concerns for their safety whilst receiving support from the service. One person told us, "I absolutely feel safe with my carer." A relative said, "I do not have any cause for concern, [named person] could not cope without their care and support." Another said, "[named person] is safe in their hands."

People, relatives and staff all told us that there were enough staff available to meet people's needs. One staff member told us, "There are enough staff. We have a group chat where we share information about cancellations and staff absences etcetera so we can organise cover." The provider monitored care visits through the use of the group messaging system to ensure people did not experience missed visits. In addition, a supervisor was employed who worked out in the field completing random spot checks to ensure staff completed their visits and stayed for the allotted time. We were advised that the care manager was able to provide direct care and support if required as a contingency plan if there were staff shortages.

People told us that staff were generally on time and that they had not experienced any missed visits. Comments included, "They turn up on time." And, "They're pretty good with time keeping, no missed calls except for one right at the beginning but all sorted now." And, "No I've never had a missed call, they have been really good." Staff told us they had enough time to make their calls and were not rushed so were able to spend time with people.

When support with medicines was provided we saw that medicines were administered safely. People had support plans, which identified the level of medication support people received and provided clear guidance for staff to follow. As part of the inspection we visited two people in their own homes and observed that medicines were given safely. People had medication administration records (MAR) which had been completed with no omissions of signatures, which indicated that people had received their medicines as prescribed. People's MAR sheets were collected regularly by the supervisor and returned to the office to be audited. The care manager told us that the time between medicine audits had been shortened to every two weeks rather than every month as they found this improved staff recording practices. We saw that the audits had been effective at picking up on any errors and these were investigated to ensure people's safety and wellbeing.

Staff told us they received medication training before providing medication support. However, we found that at the time of inspection specific medicine competency assessments were not being undertaken to monitor staff learning and check that staff had the necessary skills to support people safely with their medicines. We saw that the supervisor currently completed spot checks on staff, which looked at many areas of staff practice including administering medicines but that the current checks did not cover all aspects of safe medicine management. The care manager advised us that this failing had been brought to their attention by their local authority and showed us a competency assessment which they had developed in response which was shortly to be introduced. In addition, the care manager told us that they were attending advanced medicine training booked for February 2018 to become a 'train the trainer' in medicines management to further improve the quality and safety of their medicine management process.

We looked at the systems in place to protect people from abuse and improper treatment. We saw that where concerns had been highlighted the service had raised safeguarding referrals appropriately. We looked at three safeguarding incidents and saw that these had been investigated appropriately with the outcome recorded. Staff told us they had completed training in safeguarding vulnerable adults, which we verified by looking at training records. All the staff spoken with demonstrated an understanding of abuse and were able

to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. One staff member told us, We have a sheet we fill in for incidents or concerns; I always follow up, it's not just reporting; I always ask what's been done after; if I felt no action was being taken I would go higher."

The service had a whistleblowing policy which gave clear guidance to staff on how to raise a concern. Staff told us they were aware of the policy and procedures for whistle-blowing. We saw evidence that staff had felt confident to use the whistle blowing policy to report poor practice and this had been dealt with by the provider who had taken appropriate disciplinary action.

Staff had received training in infection control and random spot checks were completed to monitor staffs infection control practice. During our inspection visits we observed staff wearing gloves and aprons when supporting people to prevent the spread of infection. We found the service responded positively to feedback regarding infection control and took appropriate measures to make improvements where required. For example, where a person had reported that their carer had failed to wear their gloves and apron this was addressed with the staff member in supervision. In addition, the staff member was sent on an infection control awareness course where UV light was used to demonstrate to the worker how bacteria could be carried on skin and clothing.

Good

Our findings

We asked people and their relatives if they felt staff had the knowledge and skills to provide effective care. One person told us, "The care is very good." Another said, "They are good and two or three of the carers are excellent." A relative told us, "They do seem to know what they're doing."

Prior to our inspection information of concern had been shared with us regarding a lack of training for staff. However, during our inspection we found the provider had addressed this issue and all staff had received up to date training in topics that met the needs of people who used the service, for example, moving and positioning and training in dementia awareness. We looked at the induction, professional development and supervision staff received and found that the service supported staff to be competent in their role. New staff were inducted into the service using the Care Certificate standards which represents best practice in preparing staff to work in the care sector. The induction also included reading through the company policies and procedures and completing training which was a mixture of face to face and E-Learning. Staff then shadowed more experienced staff whilst they learned about the people they would be supporting. A member of staff described their induction experience. They told us, "It was really good, I did E learning, shadow shifts and face to face training and had lots of supervision." Existing staff received refresher training and were supported to develop professionally and obtain advanced qualifications in health and social care. One staff member told us, "They put me through level 2 and they are now helping me with level 3."

Historically, the service had not supported staff through consistent and regular supervision, however we found that this issue was being addressed. Records showed that staff were now receiving regular supervisions as well as direct observations and spot checks of their practice to monitor staff competence and identify any learning needs. We spoke with the care supervisor responsible for monitoring staff performance. They told us, "I work with all of the carers so I get to see all of the staff; I always check to make sure their hair is tied up, short nails, wearing the right uniform; I work with them to see how they care, what they are like. Because I work with them all the time it stops them getting nervous when I do their observations."

Staff told us they felt very well supported by the supervisor and care manager and found supervision to be a positive experience. One staff member told us, "[care manager] and [supervisor] are great, so supportive, they are always there for us." Another said, "I get regular supervision; it's very helpful; we also get spot checks regularly, we can't get away with anything." We looked at supervision records and saw that supervision was used constructively to pick up on any issues identified during direct observations of staff practice. For example, where an observation had highlighted that a member of staff was rushing people, this

was discussed in a supervision session and follow up observations were then completed to monitor staff performance and ensure that the necessary improvements had been made.

At the time of inspection the service had not completed any annual appraisals of staff practice. This meant that staff had not been provided with an assessment and overview of their performance and the opportunity to set career goals and plan for their future learning and development. We discussed our concerns with the registered manager regarding a lack of appraisals. They advised us that many of their staff had not worked at the service for a year but recognised that there were some staff whose annual appraisal was overdue. We were shown a supervision and appraisal planner that had been created with appraisals scheduled for all staff be completed in 2018.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's abilities to make various decisions had been recorded in their care plan and included information on variability, for example, if people were more disorientated in the evening. This meant that people could be supported to make informed decisions at a time that gave them the best opportunity to be included. We saw that formal assessments of capacity were now being completed and the service had developed a best interest recording form which recorded discussions with people's family or other relevant parties. This was reviewed quarterly.

We saw that staff had received training in the MCA and demonstrated an awareness of how to support people to make their own choices. One staff member told us, "I always give people choices, I chat with them and explain their options to help them choose." We looked at Minutes of Staff meetings and saw that the last meeting had been used as an opportunity to talk about the MCA to support staff skills and knowledge. This meant that people were supported by staff who understood the importance of helping people to make their own decisions. We looked at people's care records and saw that MCA assessments had been completed in circumstances where people were deemed to potentially lack capacity. We saw people's consent had been obtained prior to their care package commencing and written confirmation of this was found in all the care files we looked at.

Where it was part of an assessed care need, we checked to see how people were supported to maintain good nutrition and hydration. We found people were supported to have enough to eat and drink which met their needs. A relative told us, "The carers always leave a drink within reach for [Named person]." People identified at risk of poor nutrition had risk assessments and management plans in place. We looked at one person's records and saw that they had gained weight since receiving support from the service. Staff told us they were vigilant in ensuring people had enough to eat and drink. One staff member told us, "If people are on nutritional supplements I will always stay and make sure they have taken them." People we spoke with confirmed they could choose want they wanted to eat and drink and meals were presented how they liked them. People's care records obtained sufficient information to support staff to provide food and drink that met people's preferences. For example, one person's care plan stated; "[Named person] will choose from a variety of sandwich fillers kept in fridge."

The service supported people to maintain their health and wellbeing. Care workers told us if they noticed someone was poorly they would take the appropriate action such as calling 999 or reporting concerns to the office who would contact the GP or paramedics. People's daily notes evidenced that care staff were vigilant

in picking up on concerns. For example, in one person's daily notes an entry stated, "Noticed person unresponsive so called 999." Feedback from relatives regarding the support people received to stay healthy and receive appropriate treatment was positive. One relative told us, "Every time they ring and let us know if [named person] is unwell; They rang for an ambulance on boxing day when they noticed [named person] was poorly."

The service worked with other organisations and professionals to help them to provide effective care and promote people's safety and wellbeing. For example, if people were prescribed new equipment for moving and positioning, the prescribing occupational therapist provided training and guidance for staff. A staff member told us, "When [named person] needed a rotunda to help them stand, the OT came out and showed us how to do it then watched us to make sure we were using it properly." A relative provided feedback via a survey demonstrating how the service worked with external agencies. Their comments included; "We had concerns for [Named person] regarding dementia; the care manager followed this up and got us an appointment with the memory clinic and the social worker."

Good

Our findings

We asked people and their relatives how they felt about the caring approach of the staff. Comments from people included, "The carers are all lovely, very kind." And, "They're brilliant, they are all really kind to me." A relative told us, "[family member] is kept warm and comfortable, always well kempt, they [staff] put a glittery bow in their hair at Christmas." The caring approach of staff extended to people's relatives. For example, we saw in one person's daily notes the staff member had written, "Took over feeding [named person] so that [named relative] could eat their Christmas dinner." And, "Made [named family member] sit down with a cup of tea."

When staff visited people they wrote an account of the visit in their daily notes. People's daily notes were written in a kind and sensitive manner. The entries provided evidence of the caring approach of staff towards people. For example, one entry stated, "[Named person] a bit confused as clock had stopped. Found batteries and put clock back to right time and changed all the calendars." Another entry recorded, "Wrote [named person] a note to remind them that Tottenham and Liverpool on TV as they love football, especially Liverpool."

We observed care staff providing support to people and saw that they were polite and cheerful. Staff laughed and joked with people and engaged in conversation, helping to put people at ease. We observed staff use touch appropriately to demonstrate warmth and affection, for example, stroking a person's hand whilst helping them to eat their lunch.

People told us they were usually supported by regular staff who knew them well. One person said, "I get regular carers, mostly I know who they are; my regulars know exactly what's needed, they know my preferences, we have a routine." Consistency of care meant that staff had the opportunity to learn about people and form positive relationships. We observed one staff member ask a person, "Do you want your usual?" This demonstrated that the staff member knew the person well. Before they left they asked the person, "Is there anything else you would like me to do?."

Staff supported people to maintain their independence. One person told us, "They [staff] always respect my choices and allow me to remain independent." People's care records provided detailed guidance to staff on how to support people with their independence. For example, one person's washing and dressing care plan stated; "[Named person] fills sink with water and adds E45 and gets flannel and towel ready for carers." We saw an example where the approach of the service in encouraging independence had resulted in the person regaining physical function which meant they were able to go to church. In this way the service had also

supported the person to meet their spiritual needs.

People told us that they were included in all decisions about their care and support and that staff listened to them and provided support the way wanted. One person told us, "They [staff] do listen to me, they are very good; they do things the way I like; they always ask me if there's anything else I want them to do; they will clean the bathroom and do the fridge for me."

We looked at how the service recognised equality and diversity and protected people's human rights. We spoke with staff and members of the management team and were assured that the culture of the service was non-discriminatory and people's rights were recognised and upheld. Care records captured key information about people including any personal, cultural and religious beliefs. We saw that people who used the service could request a preference of gender and age of care worker and this was respected to help people feel comfortable and at ease with receiving care and support.

To strengthen its approach to equality, diversity and human rights, we recommend the provider consults the CQC's public website for further guidance entitled 'Equally outstanding: Equality and human rights - good practice resource.'

People's privacy and dignity was respected. Staff sought consent to enter the property before proceeding to do so. Staff told us how they protected people's dignity by making sure people were dressed and covered appropriately when providing personal care. People confirmed they were treated with dignity and respect. One person told us, "All carers are lovely and treat me with respect and always chat and have a laugh." Another said, "I have never had any rudeness from staff."

Good

Our findings

Prior to our inspection, information of concern had been shared with us regarding the poor quality of people's care and support plans. Issues identified as requiring improvement included the need for more detailed information to enable staff to deliver 'person-centred' care, which means providing care and support that is tailored to each individual.

During our inspection we were advised that new systems for assessing, recording and sharing information regarding people's needs and preferences had been implemented to promote a more person-centred approach. A new supervisor had been appointed who worked out in the field alongside staff delivering care and support to people. Information they gathered was then shared with the rest of the management team and staff and included in the person's care plan. This ensured that people's needs and preferences were known and respected. We saw evidence of this new approach in practice and found the service had begun to make the necessary improvements.

New care plans had been introduced. We looked at five of the new style care plans and found them to be of a very good quality. The service had adopted a far more holistic approach to care planning and had given greater consideration to the 'whole person'. The new care records reflected people's routines and preferences, identified people's strengths and abilities, considered people's cognition and the impact of any physical and mental health conditions. The information recorded supported staff to deliver person-centred care. For example, one person's care plan detailed how a person liked their hair to be styled, stating, "Likes a bun, a plait or a pony tail." Another person's care plan guided staff to, 'Put [named person] left arm in first when dressing them." Staff we spoke with understood the importance of taking a person-centred approach and were able to describe how they did this in practice. One staff member told us, "It's about doing things specifically for that person; we do it by reading their care plan and talking to people and asking the how they want things done."

People and their representatives, where appropriate, had been involved in the planning of their care and were included in regular face to face reviews of their care and support. Care reviews were a two way process and the feedback provided by people was listened to and acted upon. For example, we saw that a person had asked for additional support with peeling vegetables during their review. This information had been added to their care plan to instruct staff of the changes. We later spoke with the person who confirmed they were now receiving support with meal preparation.

People had a copy of their care records in their home. This included information on how to make a

complaint. All of the people and relatives we spoke with told us they knew how to make a complaint if necessary. One person told us, "I have no complaints but I know how to complain and I know that they will deal with it; [named staff] is the care manager, I have their contact number in my care book." A relative said, ""I would go to [named supervisor] if I had a problem, they phone me and keep in touch."

There were systems and processes in place to manage complaints. We found that when complaints were made these were processed in a timely way, with outcomes clearly recorded. We saw one complaint that contained a letter of apology and evidence that the provider's disciplinary process had been followed. We also saw compliments that had been received by the service. Comments included, "Thank you [named staff members] are one of a kind", and, " [Person] is so happy, [named carer] is like an angel to him", and, " Carers are very polite, discreet, honest, trustworthy and very cheerful."

Requires Improvement

Our findings

There was a registered manager in post who was also the registered provider. This person was also the registered manager of another service. At a recent inspection we found significant concerns at the other service which had resulted in a rating of 'inadequate' which meant the service was placed in 'special measures'. However, whilst historically the failings of both services were of a similar nature we found that many of the issues at this service had now been addressed. This had been accomplished through the recruitment of a new management team and input from the local authority's quality improvement team. We found that the new management structure had lead to many positive changes and the service had been supported by the local authority to address the concerns and drive significant improvements at this location.

Feedback we received from people and relatives demonstrated that the new management team had a positive impact on the service people received. This was summed up by one relative who told us, "DLCS has transformed since taking on a new manager and supervisor. It's more pleasant, more organised; The staff were always in a rush, not now; They all work as a team, it couldn't be better, the company has vastly improved."

However, it should be noted that whilst action had been taken to make the necessary improvements, these actions had been 'reactive' in response to poor performance identified at previous inspections and by the local authority. The failure to independently identify issues requiring improvement demonstrated a lack of awareness of the provider regarding their responsibilities under the Health and Social Care Act. In addition, whilst there had been significant improvements in many areas, further improvements were still required. For example, in ensuring staff competency in administering medicines, implementing a more robust recruitment process and providing staff with annual appraisals. Work had been started on making all of these necessary improvements but it was too early to comment on their quality, safety and effectiveness as the new systems had not yet been fully embedded in practice.

We did see audits being completed by the registered manager which had been effective at identifying and rectifying areas that required improvement. For example, people's care records were audited each month by the registered manager who had identified when information was missing from people' care records to ensure staff could support people safely. This was then added to the care plan to provide additional guidance for staff. People's daily notes were also audited every month when they were returned to the office. The registered manager or care manager read through the notes to check people had received all of their calls and the right level of care and support. We saw an example of an audit which demonstrated that

the registered manager had picked up where a visit had been missed. This was then investigated and the appropriate action taken. This meant…..

During our inspection we received feedback that the registered manager was not known to people or their relatives and staff told us they had limited or no contact with them. However, the lack of visibility of the registered manager was mitigated by the presence of the care manager and supervisor who were available on a day to day basis. The supervisor worked out in the field providing supervision to staff and care and support to people. The care manager was based at the office but was also available to provide direct care if needed. This hands-on approach meant that people and staff knew who to contact for support and guidance or to raise concerns. Feedback from people and staff about the care manager and supervisor was very positive. Comments included; "[care manager] is very supportive, best company I've worked for." And, "[Supervisor] is really supportive, we can phone them anytime, they will always get back to you; They have turned this company around; they are marvellous." And, "I've been here nearly 2 years, brilliant company to work for; [care manager] and [supervisor] are there for me; I have nothing to do with the registered manager."

Staff were positive about the recent changes and there was a new sense of teamwork which staff said was a result of the new management structure. A member of staff told us, "We have mutual respect for each other and we all work as a team now; it wasn't a team before." Staff meetings were held every two months and management meetings monthly to promote good communication, learning and teamwork. We saw that minutes of meetings were taken and action plans were generated which set out who was responsible for each task and by which date.

The service understood the importance of demonstrating positive values and good practice principles to staff. The management team had recognised the value of utilising the care supervisor to work out in the field providing guidance and support to staff and acting as a positive role model.

We found the service was pro-active in obtaining and listening to the views of people who used the service and used this information to drive improvements. As well as the monthly face to face reviews which were conducted by the care manager the service sent out an annual survey to ask people for their feedback. In addition, the company administrator completed monthly telephone calls to people to check they were satisfied with the service they were receiving. We saw that feedback provided during these telephone calls was acted upon so that people felt listened to and their concerns were actioned. For example, where a person was not happy with their call times, the visit times were changed in response.

Quality monitoring information was also gathered using informal means by the supervisor whilst out working in the community. We spoke with the supervisor who told us, "Not only do I do spot checks and direct observations of staff ; I also talk with clients to see everyone to make sure they ok and happy; I saw 25 people over 2 days at Christmas; Generally within 10 days I have seen everyone who uses the service."

We were advised by the care manager that further new projects were being planned to increase awareness of people and improve the safety and quality of the service people received. This included the introduction of a 'carer contribution questionnaire' which was going to be sent out to staff in January 2018. The purpose of this was so that staff could share information about people's preferences with each other, for example, what people preferred to eat, their likes, dislikes as well as information on risks or concerns about people.